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Portugal's 2001 Drugs Liberalisation Policy: A UK service provider's perspective on the Psychoactive Substances Act (2016).

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Portugal's 2001 Drugs Liberalisation Policy: A UK service provider's perspective on the Psychoactive Substances Act (2016)

Abstract

The Misuse of Drugs Act (1971) and the Psychoactive Substances Act (2016) both reinforce the criminalisation of drugs use in the UK. The Psychoactive Substances Act (2016) has been developed to control and monitor the use of legal highs, particularly in institutions. This study aimed to establish drug service providers' viewpoints on how effective UK drug policies have been at curtailing criminal behaviours and whether existing policies should be aligned with the Portuguese drug liberalisation policy. A thematic analysis was conducted following semi-structured interviews with four UK based substance use service providers. Two superordinate themes emerged and included a need for change in UK drug policy including a clearer definition of the Psychoactive Substance Act (2016) and an integrated systems approach to drug policy in line with the Portuguese liberalisation policy. This would curtail the criminalization of drug users, target those with substance misuse problems in the community and in prison, and support an attuned systems approach to treatment.

Introduction

The Misuse of Drugs Act (MDA, 1971) is the primary legislation for controlling psychoactive substances in the UK and is distinguished by ABC classes of their harmfulness. An estimated 500 substances are controlled via the MDA (Reuter, 2011). The Advisory Council on Misuse of Drugs (ACMD) was developed to guide the MDA regarding the harms associated with psychoactive substances. Despite efforts of the UK Drug Policy Commission (UKDPC) to establish an evidence based approach to the MDA classification, the ABC classification is unsupported with scientific evidence (Nutt, 2009). For example, a study conducted by Chandler et al. (2014) found that UK authorities prioritise opioid (class A) use as a drug-related problem to be addressed within the community borders through substitution therapy and residential programs, but benzodiazepine (class C) abuse is a common problem among young parents, especially pregnant women, yet remains largely ignored (Chandler et al., 2014).

The Psychoactive Substances Act (2016) has been developed to curtail the use and supply of legal highs. The manufacture and availability of legal highs is diverse where developing a suitable classification system under the Misuse of Drugs Act (1971) to criminalise these drugs is a proven challenge. The Psychoactive Substances Act (2016) states that headshops will be the focus of enforcement (Home Office, 2016). However, easy access to these substances via the internet will prove harder to monitor and control compared to headshops. Further, what constitutes a legal high is difficult to define and many of the challenges which presented the MDA will no doubt become apparent to the Psychoactive Substances Act (2016). According to this act, one is prohibited from "producing, supplying, offering to supply, possessing with an intent to supply or within places of custody, importing or exporting of any substance intended for human consumption that is capable of producing a psychoactive effect" (Nutt, King & Phillips, 2010). The Psychoactive Substances Act (2016) does not criminalise those in possession of legal highs (personal use) unless those in possession are in an institution, namely prison.

In part, the UK's drug policy's stem from the 1980s-1990s which was geared towards public health protection. Because of the growing incidence of HIV and hepatitis among the intravenous-injecting drug users, policymakers ensured the accessibility of needle exchange schemes and health education for the at-risk population segment (Monaghan, 2012). This period was characterised by treatment-focused harm reduction interventions. In 1995, the UK Tackling Drugs Together policy involved harsh criminalisation due to the high-level of drug-related criminal statistics (Monaghan, 2012). However, Hughes and Stevens (2010) argued that harsh criminalisation is a possible panacea for society, regardless of scientific evidence stating the opposite, and the fear that any steps towards decriminalisation would have "sent the wrong message" to the public (p. 999). In this respect, Newcombe (2008) has termed the UK drug policies as a "drug war." Indeed, the debate on drug policy remains polarised where the 'war on drugs' perpetuates the opinion of controlling drugs via the Misuse of Drugs Act (1971) and in part the Psychoactive Substances Act (2016).

In contrast, other Countries have employed alternate methods of control and enforcement. To expand, decriminalisation of being in drug possession for personal use includes Portugal, Czech Republic, Brazil and Bolivia (Feiling, 2011). Indeed, the Portuguese 15-year experience of decriminalisation of drugs has been widely promoted as a relevant strategy to eliminate the UK's 'war on drugs' through the adaptation of this policy framework (Feiling,

2011). Decriminalisation refers to "a new response to drug offences through administrative processes where "drug addiction is a health issue and not a criminal one" (Ponte, 2015, p. 18). As a result, the Portuguese approach entails that the individuals are allowed to acquire, possess and personally use psychoactive drugs, including cannabis, in small quantities, without being prosecuted (Greenwald, 2009; Laqueur, 2014). Other countries including for example the Netherlands, Spain and Italy have utilised civil rather than criminal penalties for those in drug possession.

Whilst the research to support decriminalisation remains contested, it appears that the drug problems in these Countries have not increased. Woods (2011) emphasised that Portugal has developed a well-shaped background for the implementation of the strategy which was aimed at reducing drug-related harm and criminal prosecution. This employs a pragmatic and humanistic approach, which prohibit the stigmatisation of drug users, and involves the Commission for the Dissuasion of Drug Addiction (CDT). CDT comprises of legal representatives along with medical and social workers. Police officers are largely not involved in the process, unless there is a need to confiscate the drugs. Therefore, the Portuguese approach is distinct from that in the UK. The Portuguese model makes drug users the centre of an integrated circle of collaboration and favours a systems approach. For example, the approach has supported rehabilitation services, housing and social security measures (Greenwald, 2009; Laqueur, 2014) where reports have confirmed a decrease in the use of problematic drugs and subsequent criminal offending behaviours (Greenwald, 2009). Additionally, Murkin (2014) suggests that Portuguese drug use rates and drug related deaths are lower than in Europe. Further, the number of arrests has decreased from 14,000 as a 2000-year indicator to 5,000-6,000 in the late 2000s and the number of the incarcerated criminals due to drug-related issues reduced from 44% to 21% between 1999 and 2012.

Felix and Portugal (2015) have explored the efficacy of the drug policies aimed at the decriminalisation of illicit drugs. The authors have analysed the trends of market prices for cocaine and opioids for 10 European countries, with Portugal as the centrepiece, and have discovered that the assumption is not always valid (Felix & Portugal 2015). Woods (2009) argues that decriminalisation will explicate potential economic advantages in a form of taxes and new business ventures among others rather than lead to drug-related violence. According to Humphreys (2013), McKeganey (2007) and Newcombe (2008), policymakers need to develop appropriate policy initiatives in conjunction with the local scientific research and in

collaboration with local professionals. Having an understanding of the mental health implications of drugs use especially via primary line professionals are critical input in supporting a systems approach and in the development of evidence based informed policies. This is an important consideration when looking at illicit drug use in the UK. The Office for National Statistics (ONS) (2016) has shown that approximately 8.6% of adult individuals within the 16-59-year age gap used an illicit drug during 2014-2015, while this percentage in 2004/2005 comprised more than 11.2%. The same indicator for UK residents aged between 16 and 24 was 19.4% and 26.5% respectively (ONS, 2016, p. 1). The use of drugs including legal highs and ecstasy for youths aged between 16 and 24 years has increased from 3.9% in 2004/2005 to 5.4% in 2014/2015 (ONS, 2016, p. 1). Although the above information may have evidenced a slight reduction in illicit drug use, drug-related crimes appear to have increased.

Lefebvre (2015) suggests that the Psychoactive Substances Act (2016) involves the "use of drugs is an evil to eradicate, thanks to hard laws efficiently enforced" (Lefebvre 2015, p. 477). The other notable perspectives on anti-drug measures are reliance on physiology and treating the drug-related issues by doctors as well as reference to social domains and the elimination of the problem in a complex manner (Lefebvre 2015). Drawing upon the controversial and contradictory statistics, the current update to the UK drug policies seems to be an unjustified step, since criminalisation has not led to a decrease in criminally offending behaviours. Significant costs are spent on the detention of prisoners which provided a breakdown of the expenditure on drug related crime reported by police in England and Wales for the period of 2011/12. From an individual perspective, use of drugs accounts for annual expenditure of £15,000-£30,000 per single user, while the number of crack and heroin users in England alone is approximately 306,000 individuals, out of which around 200,000 people undergo rehabilitation courses on an annual basis (Bennett & Holloway, 2009).

The changing trends of drug use in prison also highlights concerns over the Psychoactive Substances Act (2016). Whilst reduced levels of illicit opiates (excluding medication) are being observed in prison (former HM Inspectorate, 2015) the same cannot be said for synthetic cannabis and additional legal high substances. Since being in possession of legal highs is illegal in prison, this holds important implications regarding parole, the added costs of drugs in prison along with additional concerns such as mental health problems and overcrowding (Hawton et al.2013; Ministry of Justice2008, 2012, 2013a, b; HMP

Inspectorate of Prisons 1996; HM Inspectorate of Prisons 2013a, b, c, and HM Inspectorate of Probation & Prisons 2013 April, May, June). Criminalising these drugs may result in greater harm to prisoners rather than supporting their rehabilitation.

To date, little research has focused on service providers' viewpoints on the drugs services in the UK and the current policy which supports them. Therefore, this study looked at how drug rehabilitation service providers perceive UK drug policies and how effective they are on curtailing criminal behaviours and whether existing policies should be aligned with the Portuguese drug liberalisation policy.

Methods

Participants

The target population comprised of 4 service providers from different drug services in the UK (summarised in table 1) and consisted of 3 men and 1 woman with approximately 15 years of experience in the substance misuse field. All participants were sourced via the internet where their details were available on business-orientated social networking services. A purposive sampling method was used in order to obtain a suitable sample for this study.

Table 1: Participant profile summary

Participant	Sex	Practice	Profession	Experience	Location
1	M	Substance abuse	Counsellor	20	Birmingham
2	F	Reintegration of the target population into working sites	Counsellor/community engagement worker	15	Hampshire
3	M	Drug replacement therapy	Community drug and alcohol recovery nurse	14	Surrey
4	M	Rehabilitation centre	Project worker/CBT specialist	10	Manchester

Materials

A thematic analysis, as described by Braun and Clarke (2006), was conducted in order to gain a deeper qualitative understanding of this unknown area. The approach was flexible enough to allow participants to discuss their views on drug policy where a number of developing themes emerged. In-depth semi-structured interviews were carried out as a data collection tool (Willig, 2013). Seven main questions were formulated following a pilot study and included, for example, "What do you think about the Portuguese Drug Liberalisation Policy? And "If this policy would be implemented in the UK, what impact do you think it would have?"

Procedure

Ethical permission was secured via the institutional review board. Participants were then approached via social media sites. Following informed consent, interviews took place via skype and were audio recorded. Each semi-structured interview lasted approximately 45 minutes. The interview schedule was initially piloted with one participant in order to confirm suitability of questions; where no amendments were made. All participants were ensured confidentiality and reminded that they could withdrawal from the study at any point should they wish to terminate the interview. The information was stored in accordance with the Data Protection Act, 1988. Following each interview, participants were forwarded a debrief form including a list of supportive agencies. Recorded interviews were transcribed and thematised (Braun and Clarke's, 2006). This included familiarisation with the transcripts to ensure an in-depth comprehension of its content. This was followed by coding the data which entailed the generation of codes as relevant characteristics of the data.

To verify and refine them, created themes were independently reviewed from narratives. Feedback was sought throughout the research process to confirm the accuracy of the developing themes from the participants' viewpoint. This ensured accuracy of the researcher's interpretation of the developing themes, ensuring qualitative validity.

Results

Two main superordinate themes emerged from the data (shown in Figure 1) and included the relevance of the Portuguese Drug Liberalisation Policy in the UK and a need funded systems/integrated approach to the substance misuse field. These yielded a number of subordinate themes which highlighted the complexity of substance misuse and drug policy in the UK, policy awareness, a need for change in UK drugs policy, narrowed speciality area, and vision for improvement. The subordinate themes have been discussed under the main subordinate themes. Both the superordinate and subordinate themes are not mutually exclusive but interlinked concepts voiced by the participants in this study.

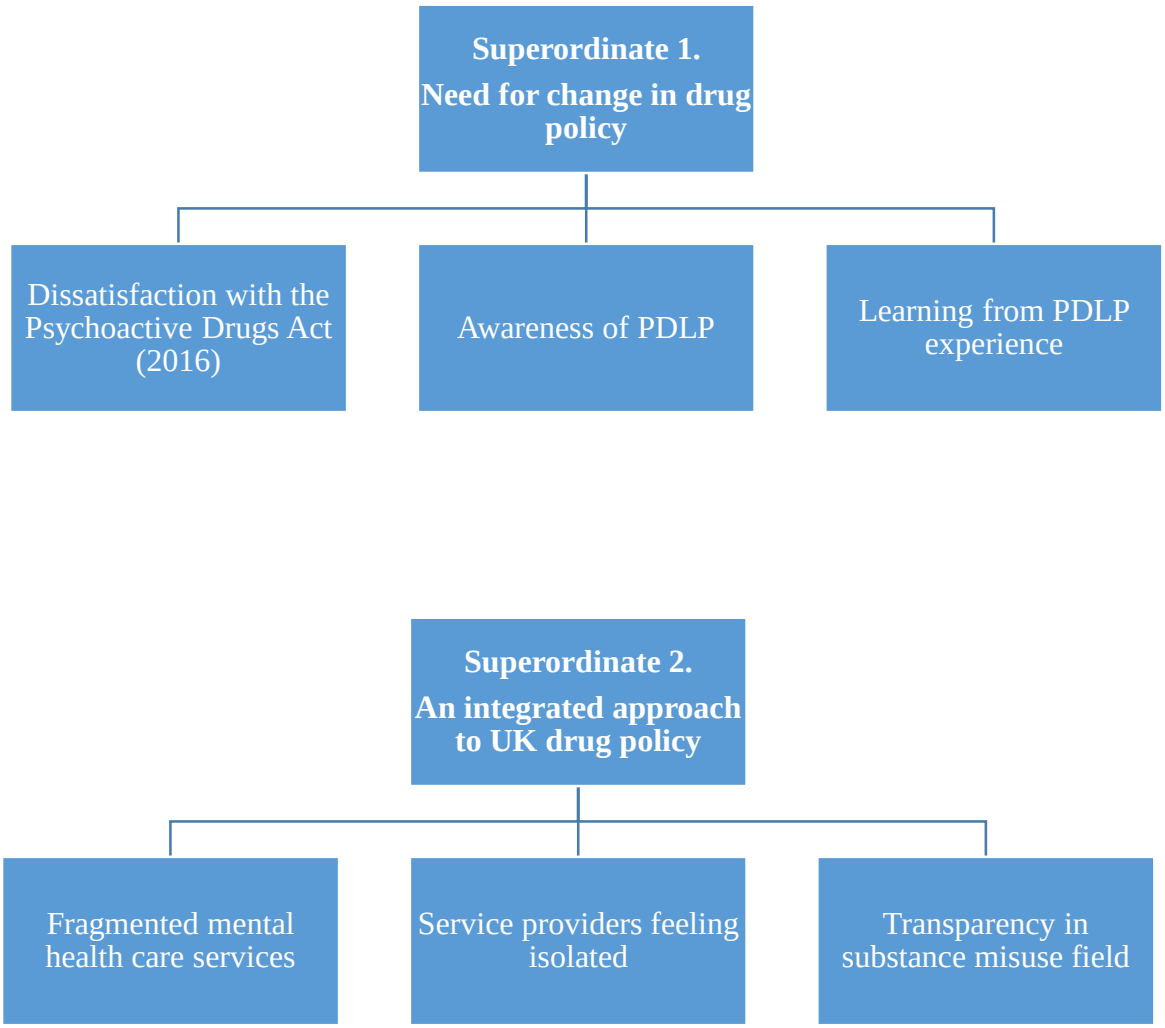

Figure 1: Thematic map

Emerged Themes

Superordinate 1: Need to for change in UK drug policy. The following subordinate themes supported the developing superordinate theme and emphasised the need for change in UK drug policy. Themes centred on the dissatisfaction with the Misuse of Drugs Act (1971) and the Psychoactive Substances Act (2016) along with having an awareness of, the PDLP experience. To expand, all participants were knowledgeable about the PDLP and its impact in

the substance misuse field. Participants suggested that they had all read the research on the drug liberalisation policy rather than rely on media content.

For example, P1 noted, *"From what I read and heard, people can carry drugs for personal use legally, and they can buy and have drugs if it's just for a person's use and it has been put in place since 2001, and it seemed to work for them."* Similarly, P2 claimed that, *"The policy has decriminalised the drugs in terms for personal use and that's the opposition for consumption of any sort of illicit drug just for personal use."* P4 also stated, *"the HIV infection rates diminished, the prison intake is diminished for those sorts of crimes, and leaving the police to deal with other crimes instead of arresting kids that are trying drugs."*

An emphasis here was made on learning from Portugal's experience. This included the need for establishing why people start using drugs to begin with and how drug users can be criminalised. By employing components of the PDLP, participants suggested that this might support drug users into treatment rather than prison being the primary choice. Indeed, by decriminalising drugs in the UK (both community and prison) could counterbalance the problems caused by the disinvestment in outreach work.

For example, P2 suggested that instead of looking "*at the fact that they're [drug users] breaking the law, we could be looking at the reasons why people started using these without having to look on the legality…. Less pressure, probably, and. … many people in the prison system wouldn't be there as they wouldn't be convicted of a crime*."

Indeed, a common theme discussed by participants was the 'sameness' of UK drug policies since the introduction of the Psychoactive Substances Act (2016). Participants were baffled at why the Psychoactive Substances Act (2016) had been introduced when many of the same principles have been outlined in the Misuse of Drugs Act (1971). They discussed that by retaining the same drug policy principles highlights the war on drugs which inevitably increases drug related criminal activity, unnecessary drug prison incarcerations and drug related deaths. Both drug policies were seen as being ineffective since the development of new 'synthetic' drugs allow its manufacturers to stay ahead of the law. Further, participants' discussed the financial burden on drug enforcement will become compromised owing to financial cuts in the public sector. Another concern voiced by participants was their confusion of what constitutes a psychoactive substance and how various substances will be classified as

this remains unclear. Participants discussed the difficulties of controlling and monitoring substances as outlined in both the Misuse of Drugs Act (1971) and the Psychoactive Substances Act's (2016) along with the 'unnecessarily high costs' incurred to support this.

For example, P1 reported, "*the next 5 years for doing the same old things, which is the current plan perhaps we should try something different because what we're doing . . . is not really working. . . And while a new strategy just came out a couple of months ago, some issues are still the same. . . And it feels a bit samey. I think we should give it a go, even if would be just in a county, instead of the whole country. We're spending money in the air as we could save it."*

Superordinate theme 2: An Integrated Approach to Drug Policy in the UK depicts how participants recognised the complexity of substance misuse and the need for an integrated system. Similarly to the Kings Fund (2012), participants stated that a lack of consistency in mental health knowledge along with institutional and professional separation can lead to a lack of cohesion in health care services resulting in missed opportunities to improve care. Indeed, as exemplified in the Office for National Statistics (2016), participants made reference to how deaths involving heroin or morphine had doubled in the last three years. Participants referred to a general lack of communication and transparency in healthcare as fragmented, inconsistent and potentially dangerous.

For example, P2 reports, *"Different places have different support. For example, in Birmingham, there was little concept of the mental health issues that come with drug use. In Liverpool, on the other hand, it was all about the mental health issues, and if these were addressed, the drug use would be stopped, and this is evident in the service that I worked at. In Manchester, we provide the service that is in balance between the two, and that's why I like it. "*

This response highlighted the lack of a single vision on the issue across the UK communities, and this factor makes the policies, or even approaching the issue, of fragmentary nature. In addition, P2 identified a relevant new paradigm of drug use as a coping strategy for the individuals suffering with the mental health issues by specifying that *"plenty of people in this country are using the prescribed drugs to help them solve their mental health problems."*

This highlighted the confusing definition of the Psychoactive Substances Act (2016) which includes the effects of drugs impacting alertness, perception of time and space mood or empathy with others and/or drowsiness (Gov.uk, 2016). Many dual diagnosed clients which are prescribed prescription medication can exhibit these 'effects/symptoms'. Therefore, differentiating between mental health symptoms, prescription medication and the effects of psychoactive substances may prove challenging. Participants argued that there was limited evidence based research to support the developing classification of the Psychoactive Substances Act (2016), particularly in light of the confusing definition and erratic nature of the changing availability of legal highs. Indeed, '*how can you criminalise a substance when you don't really know what it is*'.

The analysis further revealed a range of concerns within the narrow-scope specialties of the participants that might be regarded as an indicator of the flawed character of the UK policies in general. For example, P4 noted that *"the funding is up to the local authorities, who don't really see these issues as a big priority and I worked in different authorities and it's all more or less the same: they don't look at this issue that can be addressed in a more practice-orientated way."* On the other hand, P3 identified a shortcoming in the sphere of substance use rehabilitation: *". . . we spend so much time on script [prescribing medications that can be addictive] that almost takes us away from actually doing the recovery side of it and paperwork as well."* P2 defined the issues in more general terms as *"a wrong starting point"* since *"rules and regulations . . . see these people as criminals rather than people with problems."* Finally, P1 aptly identified such a concern as the lack of collaboration and proper communication within the cross-sectional domain and an array of drawbacks that stem from this factor:

". . . there's no framework, . . . a set of the rules to divide responsibility. Now, everyone is working on an island, and they see the other service people on their islands. And the bridge between those islands is just not there in place. So, we've got confusion, lack of respect, lots of misunderstandings, and finally, we still have our duty of care to the people that we're supposed to provide our service to."

The visionary projections of changes in the UK drug policies varied among participants through the lens of their working experiences. Specifically, P3 offered insight into transformation with regard to his area of practice, including substitution of *"prescribing . . .*

[for] changing the culture of recovery." In contrast, P1 introduced a rather holistic and thoughtful view on the issue:

Drug users need care and support; they don't need criminalising that is taking away their hopes for the future about a job, a relationship. Yeah, of course, some will become criminals. But I think we can find a better way for most of them, to follow a different path, to find out how to get support. They've got more problems than drug abuse. Along with P2 and P1's focus on the need for integrated cooperation between the related services, P4 provided an important discovery for the field in terms of the potential well-thought-out alternative to the current policy:

I think that communication between the services is really important. I often dream of a service that can do the whole job, I mean finding employment, housing, social networks etc. And if all the services are working as one, it would be much better … And it seems that there are big barriers everywhere… if there was more unity in work…, it would be more beneficial for everyone. They all should read from the same policy instead of the individual ones.

Participants highlighted the need for co-operation among different healthcare and social providers. There was a general feeling of isolation and not being supported by 'the system'. Participants argued that a biopsychosocial means of supporting substance users rather than each service provider working individually would greatly support positive outcomes when working with those with a substance use problems. Participants reported that the benefits of the health care reform (e.g. Health and Social Care Act, 2012), had not become apparent in the substance misuse field and perhaps if existing UK drug policies were aligned with the Portuguese drug liberalisation policy, that this would make a positive difference in supporting those with substance misuse problems via a systems approach.

Discussion

This study aimed to establish drug service providers' viewpoints on how effective UK drug policies would be on curtailing criminal behaviours and whether existing policies should be aligned with the Portuguese drug liberalisation policy. A thematic analysis revealed two superordinate themes and included a need for change in UK drug policy including a clearer

definition of the Psychoactive Substance Act (2016) and an integrated systems approach to drug policy in line with the Portuguese Liberalisation Policy.

Drawing on the findings of the literature review, one has to admit that no universal and verified best practice in terms of drug policy exists. To some extent, the UK's use of regulating the misuse of solvents (Intoxicating Substances Act, 1985) and increasing the use of fines and/or cannabis possession has indicated an element of flexibility. However, the UK authorities tended to follow criminalisation strategies, at least based on the evidence from the 1980s to date as outlined in the Misuse of Drugs Act (1971) and the Psychoactive Substances Act (2016). Whilst the UK has focused on criminalisation, drug policy in other Countries has centred on a harm reduction strategies and hence alternatives to criminal enforcement (Demos, 2011). For example, countries such as Australia and the Netherlands have made efforts to decriminalise certain aspects of the drug-based problems, including cannabis issues. Various conceptual alternatives can be put into practice, ranging from social and public health, as well as reintegration in to society via voluntary or paid work and family support among others (Demos, 2011).

Participants did not consider replication but rather learning from Portugal's experience due to the holistic nature of this strategy, which coincided with the opinions by Greenwald (2009), Laqueur (2014), Murkin (2014), Felix and Portugal (2015). Similarly to Easton (2016), and Humphreys (2013), participants identified a need for change in drug policy in the UK due to the 'sameness'. To expand, participants in this study and in line with Portugal's drug policies suggested that legal penalties for being in possession of drugs, particularly cannabis, should be abolished in both the community and in prison. Further, arrest and incarceration should be replaced with better and more efficient drug treatment interventions. A significant number of those who have substance misuse problems or other mental health problems are imprisoned (Hawton, Linsell, Adeniji, Sariaslan et al, 2013; Ministry of Justice, 2008; 2012; 2013a; 2013b; HMP Inspectorate of Prisons, 1996; HM Inspectorate of Probation and HM Inspectorate of Prisons, 2013April, May, June). Government cuts have impacted community and prison resources, which makes it difficult for the British Prison System to make the necessary improvements following an HM inspectorate's review. Therefore, this does not support drug using prisoners or their throughcare. Indeed, according to Banbury, Lusher & Morgan (2016) in addition to mental health issues, there are limited drugs facilities within prison and a lack of support in the community upon release whether drug services or

additional mental health care support. This is particularly concerning since prisoners may become re-criminalized in prison for being in possession of a legal high which may impact existing prisoner mental health or at the very least compromise their rehabilitation. Further, a lack of clarity of what constitutes a legal high may create inconsistencies of prisoner prosecution compounded by the limitations of mandatory drug testing to identify these drugs.

In fairness, participants did voice concerns with Portugal's drug policy centring on decriminalisation being associated with higher rates of drugs use and societal problems. Whilst it is difficult to establish whether a drug policy from one Country would work in another, participants acknowledged that after 5 years if its implementation in Portugal, illegal drugs use and rates of new HIV infection and drug deaths had declined (Greenwald, 2009).

Similarly to Reuter (2010), NASW (2013), Passos and Lima (2013) and Ponte (2014) participants supported the need for a multifactorial/systems approach to supporting those with a substance misuse problem. This research explicated a range of the intertwined issues within the UK drug-related system that undermine the efficacy of service delivery, such as (a) lack of collaboration and support across the sector, (b) poor communication, (c) differing regulations for distinct services, (d) ignorance of mental health issues in this context, (e) one-sided view on the problem in contrast to its complex nature, and (f) varying approaches both county-wide and local levels. In addition, the transition of the problem to the NHS as a single sector was found inappropriate due to an already overburdened sector. Participants were mindful that a better functioning system requires a clearer understanding of what the system is looking for and what its purpose is. This would support information sharing and transparency among those who work in the substance misuse field. The CQC might also like to guide the substance misuse field with respect to supporting transparency of information in working with the Psychoactive Substances Act (2016).

The participants in this study represented different spheres of professional practice within the UK drug rehabilitation sector. However, there are no grounds for generalisation of the study results based on 4 participants with respect to the entire range of professions in this area. Nevertheless, what became apparent was the consistency of participant responses about UK drug policies. To expand, participants argued that criminalisation is not the solution to addressing substance misuse problems. Indeed, concerns centred on increased drug related deaths, more convictions, unnecessary imprisonment, added sentencing and enforcement, all

of which are costly. Participants argued that change was needed and implementing the Portugal's drug policy into UK law may support the development of an integrated and biopsychosocial systems approach to treatment. We hope that this research provides a plateau for further research to be conducted among a broader scope of UK service providers in order to develop an evidence base to support the government integrating a comprehensive framework into drug policy addressing a systems non- criminalisation approach to substance misuse problems.

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